DEPARTMENT OF HEALTH AND FAMILY SERVICES **STATE OF WISCONSIN**
Division of Health Care Financing
HCF 11051A (Rev. 06/03)

WISCONSIN MEDICAID
PRIOR AUTHORIZATION / VISION ATTACHMENT (PA/VA) COMPLETION INSTRUCTIONS

Wisconsin Medicaid requires information to enable Medicaid to authorize and pay for medical services provided to eligible recipients.

Recipients are required to give providers full, correct, and truthful information for the submission of correct and complete claims for Medicaid reimbursement. This information should include, but is not limited to, information concerning eligibility status, accurate name, address, and Medicaid identification number (HFS 104.02[4], Wis. Admin. Code).

Under s. 49.45(4), Wis. Stats., personally identifiable information about Medicaid applicants and recipients is confidential and is used for purposes directly related to Medicaid administration such as determining the eligibility of the applicant, processing prior authorization (PA) requests, or processing provider claims for reimbursement. Failure to supply the information requested by the form may result in denial of PA or Medicaid payment for the services.

The use of this form is voluntary and providers may develop their own form as long as it includes all the information on this form and is formatted exactly like this form. If necessary, attach additional pages if more space is needed. Refer to the applicable service-specific handbook for service restrictions and additional documentation requirements. Provide enough information for Wisconsin Medicaid medical consultants to make a reasonable judgment about the case.

Attach the completed Prior Authorization/Vision Services Attachment (PA/VA) to the Prior Authorization Request Form (PA/RF) and send it to Wisconsin Medicaid. Providers may submit PA requests by fax to Wisconsin Medicaid at (608) 221-8616. Providers who wish to submit PA requests by mail may do so by submitting them to the following address:

Wisconsin Medicaid
Prior Authorization
Ste 88
6406 Bridge Rd
Madison WI 53784-0088

The provision of services that are greater than or significantly different from those authorized may result in nonpayment of the billing claim(s).

SECTION I — RECIPIENT INFORMATION

Element 1 — Name — Recipient
Enter the recipient's last name, followed by his or her first name and middle initial. Use the Eligibility Verification System (EVS) to obtain the correct spelling of the recipient's name. If the name or spelling of the name on the Medicaid identification card and the EVS do not match, use the spelling from the EVS.

Element 2 — Age — Recipient
Enter the age of the recipient in numerical form (e.g., 16, 21, 60).

Element 3 — Recipient Medicaid Identification Number
Enter the recipient's 10-digit Medicaid identification number. Use the recipient's Medicaid identification card or the EVS to obtain the correct identification number.

SECTION II — PROVIDER INFORMATION

Element 4 — Name — Referring / Prescribing Provider
Enter the name of the referring/prescribing provider, if available.

Element 5 — Referring / Prescribing Provider's Medicaid Provider Number
Enter the eight-digit Medicaid provider number of the referring/prescribing provider, if available.

Element 6 — Telephone Number — Referring / Prescribing Provider
Enter the referring/prescribing provider's telephone number, including area code.

SECTION III — DOCUMENTATION

Element 7 — Lenses and Frames
List information regarding lenses and frames. Lens formula information is required for all requests for frames and lenses.

Element 8 — Special Lens / Frame Request
List information regarding special lens/frame request. Lens formula information is required for all requests for frames and lenses.

Element 9 — Tints
List information regarding lens tint. All requests for tints must include specific documentation of visual or medical necessity from the prescribing provider.

Element 10 — Other Vision Services Requested
Indicate any other vision services requested, including a description of the services requested, pertinent history/findings, and justification.

Element 11 — Signature — Requesting / Performing Provider
Enter the signature of the requesting/performing provider.

Element 12 — Date Signed
Enter the month, day, and year the PA/VA was signed (in MM/DD/YYYY format).